

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Paperbark House	CHAPTER 100.1
Address: 1038 Mokapu Boulevard, Kailua, Hawaii 96734	Inspection Date: April 9, 2021 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

27 APR 27 09:39
STATE OF HAWAII
DOH-CHCA
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> Administrator, substitute care giver (SCG) #1, SCG #2, SCG #4 - No physical examination. Submit a copy for each with the plan of correction (POC).</p>	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>1) SCG #1 no longer employed. 2) Physical Examination has been obtained/cleared by an outside healthcare provider. for Administrator, SCG #2 & SCG #4</p> <p style="text-align: right;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p>4/21/21</p> <p>21 APR 27 A9:39</p>

RULES (CRITERIA)		PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. <u>FINDINGS</u> Administrator, substitute care giver (SCG) #1, SCG #2, SCG #4 - No physical examination. Submit a copy for each with the plan of correction (POC).	<p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><u>FUTURE PLAN</u></p> <p>Future Plan: Administrator has created a separate binder of employee files which include: health clearance, TB forms/clearance, First Aid/CPR/trainings, etc. A spreadsheet was also created to help track due dates to be managed by Administrator.</p>	4/18/21	

STATE OF HAWAII
DOH-ONCA
STATE LICENSING

21 APR 27 A9:39

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. FINDINGS Administrator, SCG #2, SCG #3 - No tuberculosis clearance. Submit a copy for each with the POC. ^{Adm} PCG, SCG #4, SCG #5 - There was no screening for symptoms consistent with pulmonary TB. Submit a copy for each with the POC. SCG #4 No initial two-step TB clearance. Submit a copy of a single TB skin test with the POC.	<p style="text-align: center;">PART I</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Correction: TB clearance has been received/ provided for Administrator, SCG #2 and SCG #3.</p> <p>2) PCG, SCG #2 and SCG #5 had TB screening/attestation completed and reviewed by an outside healthcare provider.</p> <p>3) SCG #4 had 2nd step PPD completed.</p> <p>4) ^{error} SCG #5 was</p> <p style="text-align: right;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p style="text-align: right;">4/21/21</p> <p style="text-align: right;">21 APR 27 A9:39</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. <u>FINDINGS</u> Administrator, SCG #2, SCG #3 - No tuberculosis clearance. Submit a copy for each with the POC. PCG, SCG #1, SCG #5 - There was no screening for symptoms consistent with pulmonary TB. Submit a copy for each with the POC. SCG #4 No initial two-step TB clearance. Submit a copy of a single TB skin test with the POC.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Future Plan: Administrator has created a separate binder of employee files which includes Health Clearance, TB clearance, First Aid/CTP/ trainings, etc. A spreadsheet was also created to track due dates. Administrator to ensure all employee requirements are met during hire and during employment for the ARCH.</p> <div style="text-align: right;"> STATE OF HAWAII DOH-CHCA STATE LICENSING </div>	<p style="text-align: right;">4/18/21</p> <p style="text-align: right;">21 APR 27 A9:39</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-13 <u>Nutrition.</u> (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. FINDINGS No substitutions recorded when menu is not followed.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p style="text-align: right;">STATE OF HAWAII DOM-CHCA STATE LICENSING</p>	<p style="text-align: right;">21 APR 27 19:39</p>



RULES (CRITERIA)

§ 11-100.1-1.3 Nutrition. (b)

Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus.

FINDINGS

No substitutions recorded when menu is not followed.

PLAN OF CORRECTION

PART 2

FUTURE PLAN

USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?

- The substitute menu is a separate menu of alternative items that the residents may choose to have. This is different from the regular menu which is on a 6 week rotation. The substitute menu is posted and does not change. The regular menu is changed weekly.
- All caregivers are trained to follow the menu, or upon resident's request can choose an item from the substitute menu instead. All changes are logged on the substitute log, which is also posted.
- Administrator (Boyle) is responsible to change the regular menu weekly, and substitute menu items will remain the same.
- Caregivers on duty will be responsible to log any substitutions on the substitution log, and follow the substitution menu as alternative meal options.

Completion
Date

4/15/21

STATE OF HAWAII
DOH-CHCA
STATE LICENSING

21 JUL -9 P2:33

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; <u>FINDINGS</u> Resident #1 - No two-step TB clearance. Submit a copy of one TB skin test with the POC.	<p style="text-align: center;"> <u>DID YOU CORRECT THE DEFICIENCY?</u> PART 1 USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Correction: 2nd step PPD completed. </p> <p style="text-align: right;"> STATE OF HAWAII DOH-OHCA STATE LICENSING </p>	<p style="text-align: right;">4/16/21</p> <p style="text-align: center;">21 APR 27 A9:39</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1 - No two-step TB clearance. Submit a copy of one TB skin test with the POC.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Future Plan: A spreadsheet was created by nursing staff to track due dates for resident health requirements such as physical and TB annual/screening. PCG/nursing to track due dates.</p>	<p style="text-align: right;">4/18/21</p> <p style="text-align: right;">21 APR 27 A9:39</p> <p style="text-align: right;">STATE OF HAWAII DOH-ONCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (e)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><u>FINDINGS</u> Fire drills did not include residents participating in the drill.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p>STATE OF HAWAII DOH-ONCA STATE LICENSING</p>	<p>21 APR 27 A9:39</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment</u> (g)(3)(D) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request. <u>FINDINGS</u> Fire drills did not include residents participating in the drill.	<p align="center"> PLAN OF CORRECTION PART 2 <u>FUTURE PLAN</u> </p> <p align="center"> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? </p> <ul style="list-style-type: none"> - Administrator will be responsible for completion of fire drills. - The fire drill record has been updated to include a separate column to record all residents that participated. We also included instructions on the fire drill record to restate points of exits. <p align="right"> STATE OF HAWAII DOH-CHCA STATE LICENSING </p>	<p align="center">4/9/21</p> <p align="right">21 JUL -9 P 2:33</p>

Licensee's/Administrator's Signature:



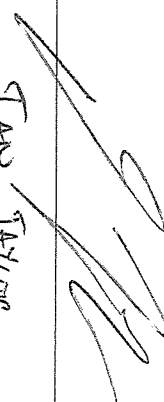
Print Name:

Ianu Taylor

Date:

4/23/21

Licensee's/Administrator's Signature:



Print Name:

Ianu Taylor

Date:

7/6/21

STATE OF HAWAII
DOH-ONCA
STATE LICENSING

21 APR 27 A9:39